COLORADO
CHILD HEALTH
PLAN

5250 Leetsdale Drive, Suite 105
Denver, Colorado 80222
303 372-2160 • 800 359-1991
FAX 372-2157

Dear Parent,

Thank you for inquiring about the Colorado Child Health Plan. The Plan is a state health program designed to deliver outpatient medical care to children under the age of thirteen who are not eligible for Medicaid.

We have enclosed an application and a list of participating primary care providers. Also enclosed is a pamphlet which details plan benefits and provides income eligibility guidelines. Please include all children on the same application.

Even if your gross annual income seems to exceed the maximum for your family size, you may still qualify for the Colorado Child Health Plan. If you are not sure of your eligibility, I also encourage you to submit your application. If it appears that you might be eligible for Medicaid, we will notify you by letter and will answer any questions pertaining to health care services available through the State of Colorado.

Please call with any additional questions. Our toll free number is 1-800-359-1991 or 372-2160 in the Denver metro area.

Sincerely,

Bonnie Sherman
Manager, Colorado Child Health Plan

COLORADO CHILD HEALTH PLAN
Administered by the University of Colorado Health Science Center
5250 Leetsdale Drive, Suite 105
Denver, Colorado 80222
(303) 372-2160 (800) 359-1991

Está forma se pueda optener en español.

Application

Please type or print in ink.

For Colorado children who:
- are age 12 or under
- are living in a participating county*
- are in a financially qualified family*
- are not eligible for Medicaid

*See the enclosed brochure

1. Eligibility

Eligibility for the Colorado Child Health Plan is based on family size, income, assets, expenses and medical expenses. Children who are eligible for Medicaid are not eligible for the Colorado Child Health Plan. **However, you do not need a Medicaid denial to apply for this plan.**

Have you applied for Medicaid for yourself and/or your child(ren) within the past 12 months? ☐ Yes ☐ No

- ☐ If the answer is "No", please continue with this application.
- ☐ If the answer is "Yes", and you have been denied Medicaid, please provide a copy of the Medicaid denial, and continue with this application.
- ☐ If the answer is "Yes", and you receive Medicaid, you are not currently eligible for this program.

2. Children

List all children in the family. Enclose a photocopy of proof of birth for each child being enrolled.

Write Y for Yes, or N for No.

Last Name, First Name *List children enrolling at this time:*	Sex M or F	Age	Birthdate (mo.,day,yr.)	Social Security Number	U. S. Citizen or Documented Alien?	Child lives with parent or guardian listed in #3 below?	Child lives with working step parent.	Step parent has adopted child.
List other children not being enrolled at this time:								

Attach an additional piece of paper if you need more space.

3. Parents/Guardians

Mother/Guardian: Last Name	First Name	Initial	Social Security No.	Birthdate (mo., day, yr.)	Work Phone ( )
Father/Guardian: Last Name	First Name	Initial	Social Security No.	Birthdate (mo., day, yr.)	Work Phone ( )
Address Where Children Live	City	County	State	Zip Code	Home Phone ( )
Mailing Address (if different from above)	City	County	State	Zip Code	

4. Family Size

For the Child Health Plan, your family may include yourself, your spouse, children, stepchildren, adopted children, unborn children (count a pregnant woman as 2 people), grandchildren, step-grandchildren, parents, step-parents, parents-in-law, grandparents, brothers, sisters, step-brothers, step-sisters, sisters-in-law, brothers-in-law, sons-in-law, and/or daughters-in-law who are living with the child you are enrolling. You may count, as a family member, any related person(s) who receives at least 50% support from the family's wage earner(s). You may also count, as a family member, any related person(s) who appears as a dependent on the family's income tax return.

How many people are there in your family? ___ Number of working adults ___ Number of non-working adults ___

Number of unborn children ___ Number of live children ___

5. Employment Income

List all employed family members in your household age 18 or over. Attach copies of worker's last three month's paycheck stubs, or a recent paycheck stub with a year to date amount with the date of original employment, or a payroll report from your employer, or business records of self-employment income. A copy of last year's tax return is acceptable only if no other proof of income is available.

Name of Worker	Employer	How Long At This Job?	Average Hours Per Week	Personal Income, Salary or Wages	Payment Periods (weekly, biweekly, monthly)

6. Non-work Income

List any income you or anyone in your family is receiving from non-work sources. **Please provide proof of this income.** Non-work income is any money received from sources other than employment, **including, but NOT limited to:**

Cash Gifts	Worker Compensation	Social Security	Child Support	Inheritance
Rental Income	Short-term Loans	Educational Grants	Alimony	Military Allotment
Unemployment Compensation	Interest Income	Railroad Benefits	Subsidized Room and/or Board	

Type of Non-work Income*	Name of Person Who Receives	Amount Received in the Last 12 Months
		$
		$
		$
		$
		$

7. Monthly Expenses (skip this section if you have completed 5 and/or 6 above.)

This is an alternative method of determining income based on monthly expenses. Please show how much you pay each month for each category below. **Document the starred* items with three months' cancelled checks or receipts.**

$_____	*Room	$_____	*Auto Loan	$_____	Groceries
$_____	Board	$_____	*Auto Insurance Premiums	$_____	Cosmetics
$_____	*Mortgage or Rent	$_____	Auto Maintenance/Gasoline	$_____	Diapers/Formula
$_____	*Electricity, gas	$_____	Clothing	$_____	Personal Expenses
$_____	*Water/Sewer/Trash	$_____	*Child Care Expenses	$_____	*Charge Card Payments
$_____	*Telephone	$_____	*Loan Payments	$_____	Other Misc. Monthly Payments
$_____	Entertainment	$_____	Subscriptions (Newspapers, Magazines, etc.)		

8. Income Exceptions

If you think your income is too high to qualify for the Child Health Plan and you answer yes to any of these questions, eligibility exceptions may be made in your favor. Please attach an explanation and documentation for each question to which you answer "Yes."

Do you expect your household income for this year to be significantly less than last years' income? ..... ☐ Yes ☐ No

Is the wage earner(s) in your family disabled? ..... ☐ Yes ☐ No

Is the wage earner(s) in your family retired, or will (s)he retire within the next 12 months? ..... ☐ Yes ☐ No

Is the wage earner(s) in your family unemployed due to factors beyond his/her control? ..... ☐ Yes ☐ No

Is the wage earner(s) in your family a seasonal worker? ..... ☐ Yes ☐ No

Has there been a change in family structure due to death, divorce, or separation since the last tax return period? ..... ☐ Yes ☐ No

Has the wage earner filed for bankruptcy within the last 3 months? ..... ☐ Yes ☐ No

Has the wage earner changed jobs within the last 12 months? ..... ☐ Yes ☐ No

Is a temporary illness within the family causing less income to be earned? ..... ☐ Yes ☐ No

9. Assets, Expenses and Liabilities Information

YOU MUST COMPLETE THIS SECTION. If you own more than one vehicle, please list the market value and what you owe for each. If you need more room, please attach a separate sheet of paper. Include farm vehicles in business worth, below.

Do you or a family member own any vehicle(s) (car, truck, motorcycle, boat, trailer)? ☐ Yes ☐ No
- If yes, how much is the vehicle(s) worth now? $ _____
- How much do you still owe on the vehicle(s)? $ _____

Do you or a family member own houses, land, or other real property other than your primary residence? ☐ Yes ☐ No
- If yes, what is the total value now? $ _____
- How much do you still owe on the property? $ _____
- Do you receive income from this property? ☐ Yes ☐ No
- If yes, how much income do you receive from the property per year? $ _____

Do you or a family member own a farm or business? ☐ Yes ☐ No
- If yes, how much is the farm or business worth now? $ _____
- How much do you still owe on the business? $ _____

How much cash or liquid assets do you and your family members have? (include savings accounts, checking accounts, stocks, bonds, cash value in a life insurance policy, and cash on hand) $ _____

10. Extraordinary Expenses

Attach proof of payment during the last 3 months (receipts and/or copies of cancelled checks).
Documented expenses listed in this section will reduce gross income used to determine eligibility.

Do you or a family member pay any medical bills monthly? ☐ Yes ☐ No
- If yes, how much do you currently pay per month? $ _____
- How much is due and payable within the next 12 months? $ _____

Do you or a family member pay for daycare? ☐ Yes ☐ No
- If yes, how much do you pay per month? $ _____

11. Insurance Information

Families with no health insurance and families with health insurance with an individual deductible of $250 or more qualify for the Colorado Child Health Plan.

Do you or a family member pay health and/or hospitalization insurance premiums? ☐ Yes ☐ No
- If yes, how much do you pay per month? $ _____

Is your child(ren) covered by a health insurance plan? ☐ Yes ☐ No
- Have you recently cancelled a health insurance plan? ☐ Yes ☐ No
- If you answered yes to either question, what is the name of the plan(s)? _____ (Insurance Company and Plan) $ _____ (Individual Deductible)

Is your child enrolled in the Health Care Program for Children with Special Needs? ☐ Yes ☐ No
- If yes, please write that child's name here. _____

12. Select a Primary Care Provider (PCP)

Choose a primary care provider from the list in this application. When you qualify for the Child Health Plan, you always take your child to this doctor's office. Your child may be seen by any physician or practitioner in the practice except those marked "existing patients only."

Write the name of the primary physician's practice you have chosen here: _____
- Is your child(ren) an existing patient of this practice or will (s)he be a new patient of this practice? ☐ Existing ☐ New

Please turn to the back to complete this application.

If you need help completing this application, please call 1-800-359-1991 or in Metro Area (303) 372-2160.

13. Enrollment Fee

For each child applying, enclose $25 in the form of a check or money order made out to The Colorado Child Health Plan. Please do not send cash. If your child(ren) does not qualify, your enrollment fee will be refunded.

☐ I have enclosed $_____ to enroll _____ children at $25 per year per child.

If payment of the enrollment fee presents a hardship you may request a payment plan or a sponsorship.

☐ I request a payment plan. I have enclosed $ _____ and I will pay $ _____ per month.

☐ I have made at least partial payment for one child. I request a sponsorship for _____ additional children.

14. Important

If this application is not completed in its entirety and the required documents enclosed, the application cannot be processed and your children cannot be enrolled.

Use the checklist below to be sure you have completed all sections of the application and included all documents:

- ☐ All sections are completed.
- ☐ Photocopies of income documents are enclosed (Originals will not be returned).
- ☐ Medicaid documents are enclosed (Originals will not be returned).
- ☐ For each child to be enrolled, enclose a photo-copy of a birth certificate, hospital birth record, or baptismal record.
- ☐ The application is signed and dated.
- ☐ Enrollment fee.

I, _____ (parent/guardian) authorize the release of financial information from or to Medicaid, Colorado Indigent Care Program, and any other agencies required to process this application.

X _____ _____

Signature Date

I, _____ (parent/guardian), certify that the information provided in the application is accurate and complete. I understand that if I knowingly make false statements on this application, I am committing a class 2 misdemeanor which is punishable by a maximum of twelve months imprisonment or a $1,000.00 fine (or both). I release the provider under the Colorado Child Health Plan from any liability or claims pertaining to the disclosure of pertinent financial, medical and nursing information from my child(ren)'s case record to the Colorado Child Health Plan, for use as determined by the Plan to accomplish its purposes. I understand that the provider has the right to obtain any recovery or right of recovery for a patient who would have a right of recovery. This means that if I am found to have a claim for any benefits payable for any treatment which is given while my child(ren) is eligible for the CCHP that this provider has the right to be included in the claims process.

X _____ _____

Signature Date

15. Where did you hear about CCHP? (Check as many as apply.)

☐ Newspaper	☐ TV	☐ Radio	☐ Poster	☐ Brochure	☐ Health Dept
☐ Social Services	☐ WIC	☐ Doctor's Office	☐ School	☐ Friend	☐ Relative

☐ Other (please specify) _____

Mail this application with all enclosures in an envelope addressed to:

The Colorado Child Health Plan
5250 Leetsdale Drive, Suite 105
Denver, CO 80222

Please allow 15 working days for processing. If your child(ren) qualifies, coverage begins on the date postmarked on the envelope in which the application is mailed. You will receive an enrollment packet, and later, a health plan membership card.

If you need help completing this application, please call

1-800-359-1991 or in Metro Area (303) 372-2160.